INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/ HealthWatch Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: October 13, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: December 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of January 1, 2019 Published: December 17, 2019	Scheduled update: • Reorganized and edited text as needed for clarity • Updated links to the new IHCP website • Added relevant information from the *Medical Policy Manual* • Updated the note box at the beginning of module • Added EPSDT objectives in the *Program Overview* section • In the *EPSDT Eligibility* section, added that members are informed about the EPSDT program and that member participation is voluntary • Clarified information in the *Fee-for-Service Members* section • Expanded the *Diagnostic Services and Follow-Up Treatment* section • In the *Prior Authorization* section, added that individual treatment services may require PA • In the *Development Surveillance* section, added exceptions to EPSDT visits requiring developmental surveillance • In the *Maternal Depression Screening* section, clarified when the screening should be done and how it is billed	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Updated the *Hearing Observation and Screening* section • Updated the list of disorders in the *Newborn Screening* section and added a link to the ISDH newborn screening web page • Added references and links for the INSTEP and IBDR programs in the new *Reviewing and Reporting Results* section • In the *Immunizations* section, added links to additional resources for the VFC program • In the *Blood Lead Screening* section, clarified when subsequent screenings are required and added provider responsibilities reporting for results • Updated risk-assessment information for lead exposure in the *Verbal Risk Assessment* section • Clarified procedures for venous blood samples in the *Procedures for Sending Blood Samples for Lead Testing* and *Billing for Blood Lead Testing Services* sections • Added the *Comprehensive Environmental Lead Testing* section • Removed the *Urinalysis* section and subsections regarding urinary albumin and sugar testing and bacteriuria screening • Updated *Section 7: Oral Health – Risk Assessment, Referral, and Preventive Dental Care* • Changed web page reference in the *Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger* section • Added CSHCS contact and website information in the *Children's Special Health Care Services* section • In the *Indiana's First Steps Program* section, added web page reference and clarified billing information	

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Section 1: Program Overview

Note:	*For updates to coding, coverage, and benefit information, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

The federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, referred to as EPSDT/HealthWatch in Indiana, is a preventive healthcare program designed to improve the overall health of Medicaid and CHIP eligible individuals from birth through the month of their 21st birthday. Special emphasis is given to early detection and treatment of health issues, as these efforts can reduce the risk of more costly treatment or hospitalizations that can result when detection is delayed.

The objectives of the EPSDT program are:

- To increase the number of members who are up-to-date with their childhood immunizations
- To increase the number of members receiving an initial health examination
- To increase the number of members receiving a preventive care/well-visit examination
- To promote interaction between the member and provider by developing and coordinating preventive services
- To encourage members to take a more active role in managing their health

The EPSDT program consists of two mutually supportive operational components:

- Ensuring the availability and accessibility of required healthcare resources
- Helping Medicaid members and their parents or guardians effectively use these resources

The Indiana Family and Social Services Administration (FSSA) is collaborating with the Indiana Chapter of the American Academy of Pediatrics (INAAP) to develop policies and programs aimed at improving the quality of children's healthcare and children's health outcomes. See the INAAP website at inaap.org. The FSSA has elected to make Bright Futures the standard for infant, child, and adolescent health supervision. See the Bright Futures website at brightfutures.aap.org.

EPSDT/HealthWatch is a required component of Indiana Health Coverage Programs (IHCP) managed care and fee-for-service (FFS) programs for members who fall within the age range for EPSDT. Specific rules about EPSDT/HealthWatch services can be found in *Indiana Administrative Code 405 IAC 5-15*.

EPSDT Eligibility

EPSDT/HealthWatch services are available to IHCP members from birth through the month of the member's 21st birthday. Each eligible member will be informed about the program by the IHCP in accordance with federal regulations. Participation in EPSDT by IHCP members is voluntary.

Members eligible for EPSDT services may be enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, or Traditional Medicaid. It is important to understand the program in which the member is enrolled and follow that program's procedures for billing. Additional information about IHCP programs can be found in the *Member Eligibility and Benefit Coverage* module and on the *IHCP Programs and Services* page at in.gov/medicaid/providers.

The State ensures that required services will be provided to qualified individuals recognized as part of a Tribal Nation. The methods and standards for payment are consistent with the current program – not less than one of the following:

- The federal Medicare reimbursement rate for the services provided
- A rate of 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate

Providers may choose to offer EPSDT screenings to only those IHCP patients assigned to their practice or currently being seen in their office. There is no requirement that an IHCP provider accept new patients.

Managed Care Members

Members enrolled in HIP, Hoosier Care Connect, or Hoosier Healthwise have a designated health plan and primary medical provider (PMP). The PMP is expected to personally provide or authorize most primary and preventive care services, including EPSDT services.

The FSSA has contracted with the following managed care entities (MCEs) to manage the care of eligible members and ultimately improve their quality of care and health outcomes:

- Anthem: anthem.com
- CareSource Indiana: caresource.com
- Managed Health Services (MHS): mhsindiana.com
- MDwise: mdwise.org

Providers rendering services to members enrolled in a managed care program must refer to the member's MCE for any additional policies specific to that network. For a complete list of contact information, see the *IHCP Quick Reference Guide* available at in.gov/medicaid/providers.

Fee-for-Service Members

IHCP members not enrolled in a managed care program are covered under an FFS program, such as Traditional Medicaid. EPSDT services are covered for all Traditional Medicaid members under age 21.

EPSDT-eligible members covered under the FFS delivery system may receive EPSDT/HealthWatch screenings from any provider that is enrolled in the IHCP, licensed to perform an unclothed physical exam, and providing the components listed in the *Required Components of EPSDT/HealthWatch* section of this module.

Required Components of EPSDT/HealthWatch

Ensuring that all children in the IHCP receive age-appropriate, comprehensive preventive services is the primary goal of the EPSDT/HealthWatch program. Components of the screenings and the recommended frequency of the screenings are listed in the Bright Futures/American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* (periodicity schedule) at aap.org.

The coverage of EPSDT services and benefits is mandatory for all individuals under age 21 who are eligible for Medicaid. Physicians are accountable for making these services available to all Medicaid-eligible patients; however, members may choose not to participate.

Note:	*According to 405 IAC 5-15-2, a screening, or any portion of a screening, is not required when medical contraindications are documented.*

To provide quality assurance for members who participate in the EPSDT/HealthWatch program, and to claim a higher level of reimbursement for EPSDT services, the following components must be provided and documented:

- Comprehensive health and developmental history, including assessment of physical and mental health development
- Physical examination

  A comprehensive unclothed physical exam is required at each EPSDT visit. Guidelines for evaluating the general physical and mental health status for infants, children, and youth to the age of 21 years are described in *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* at brightfutures.aap.org.
- Nutritional assessment

  A nutritional assessment is required at each EPSDT visit. Assessment is based on the child's health history, physical exam including oral exam, growth pattern, and appropriate blood work. It is also recommended that providers plot body mass index (BMI) beginning at age 2.
- Developmental surveillance or screening:

  A developmental assessment is required at each EPDST visit. The detection of developmental delays is an integral component of well-child care.
  - *Developmental surveillance* (the process of recognizing children who may be at risk of developmental delays) should be incorporated into every EPSDT visit, except for the 9-month, 18-month, and 30-month visits.
  - *Structured developmental screening* (the use of standardized tools to identify and refine the risk of developmental delays) should be administered regularly during the 9-month, 18-month, and 30-month visits.
- Psychosocial/behavioral assessment

  A psychosocial/behavioral assessment is required at each EPDST visit. This assessment should be family centered and may include an assessment of child's social-emotional health, caregiver depression, and social determinants of health.
- Vision assessment or screening

  Vision assessment or screening is required at each EPSDT visit. Assessment or screening is dependent on the age of child at the visit. Any screening that was not done due to a previous missed appointment should be done in lieu of an assessment. (The objective screening is not separately billable.) Direct referral to an optometrist or ophthalmologist is required when objective screening methods indicate a referral is warranted.
- Hearing assessment or screening

  Hearing assessment or screening is required at each EPSDT visit. Any screening that was not done due to a previous missed appointment should be done in lieu of an assessment. Required testing with audiometer or audioscope at 4 to 5 years old should be administered in the PMP's office (the simple hearing observation screening is not separately billable), or the patient should be referred to a hearing specialist.

- Oral Health

  An oral health risk assessment, including oral observation and examination, is required at the 6-month and 9-month EPSDT visit. The risk assessment, as well as referrals to a home dentist, should also be provided at subsequent visits when indicated. Fluoride varnish can be applied at visits as early as 6 months or when the first tooth erupts.

- Administration of or referral to any laboratory tests, procedures, or immunizations appropriate for age and risk factors at corresponding EPSDT visit

- Health education

  Patient health education is a required component of EPSDT services, and should include documented and appropriate anticipatory guidance. Education and guidance should be conveyed to parents or guardians and children, and designed to assist in understanding what to expect in terms of the child's development, healthy lifestyle choices, and accident and disease prevention. At the outset, the physical and dental screenings provide the initial context for providing health education.

Diagnostic Services and Follow-Up Treatment

Providers must assist in setting appointments on behalf of EPSDT/HealthWatch participants who need diagnostic services or follow-up treatment when indicated as a result of a screening. These additional services may require PMP authorization when performed by a provider other than the member's PMP.

Any enrolled IHCP provider may provide EPSDT diagnostic and/or treatment services, within their scope of practice, upon referral from the screening provider. If assistance is needed to locate a specialist enrolled in the IHCP for referral purposes, contact the member's MCE. For members who do not have an MCE, providers can use the IHCP Provider Locator search tool, accessible from the home page at in.gov/medicaid/providers.

Note:	*HealthWatch/EPSDT providers are required to make dental, vision, hearing, and lead screening referrals when screening results indicate a problem.*

Any treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided, subject to any prior authorization requirements for the service. If a service is not covered under the State Plan, it is still available to EPSDT members, subject to prior authorization requirements of *405 IAC 5-4*, if it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Providers who perform screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services.

Periodicity Schedule

Every child and family is unique; therefore, the Bright Futures/AAP periodicity schedule at aap.org has been designed as a preventive healthcare plan for children with the absence of any significant health problems and who are growing and developing in satisfactory fashion. This schedule can be adjusted to meet the healthcare needs of specific patients.

The periodicity schedule is meant to be a guide for IHCP providers participating in the EPSDT/ HealthWatch program. Providers are encouraged to follow recommendations outlined by the AAP. This program emphasizes the importance of early and periodic screening for specific conditions and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this schedule.

Section 2: Billing and Reimbursement for EPSDT/HealthWatch Services

Providers must furnish all components of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch examination in accordance with the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org, document services performed or referred, and include all applicable diagnosis codes for each EPSDT screening exam on the appropriate medical claim form or electronic transaction.

To ensure adherence to EPSDT requirements, the Indiana Health Coverage Programs (IHCP) monitors the following:

- Timely screening as recommended by the Bright Futures/AAP periodicity schedule includes:
  - Timely administration of immunizations
  - Hematocrit/hemoglobin testing
  - Blood lead testing
  - Urinalysis
  - Audiometric testing
- Follow-up treatment for diagnosed conditions

EPSDT/HealthWatch Billing Procedures

EPSDT/HealthWatch claims are billed on the professional claim – 837P transaction or Provider Healthcare Portal (Portal) professional claim type if submitted electronically or the *CMS-1500* claim form, if submitted on paper. Indiana does not require providers to bill EPSDT screenings on a separate EPSDT medical claim form. See the *Claim Submission and Processing* module, the *Provider Healthcare Portal* module, and the *837P Health Care Claim: Professional Transaction* on the *IHCP Companion Guides* page at in.gov/medicaid/providers for complete directions for fee-for-service claim submission. For managed care claims, follow the claim submission procedures for the member's assigned managed care entity (MCE).

The following billing procedures must be followed for every EPSDT/HealthWatch claim, to permit correct and prompt reimbursement:

- Providers must use the ICD-10 diagnosis codes **Z00.121** – *Encounter for routine child health examination with abnormal findings* or **Z00.129** – *Encounter for routine child health examination without abnormal findings* as the primary diagnosis for EPSDT claims.

  The appropriate preventive health diagnosis code must be used as the **primary** diagnosis (the first diagnosis code entered in the diagnosis code field). Any other applicable diagnosis codes must be entered in the other positions in the diagnosis code field and cross-referenced accordingly in the diagnosis pointer field for each service detail.
- The appropriate Current Procedural Terminology (CPT®[1]) code for initial or established patient exams (see Table 1) must be included on the first detail line of the claim. For the procedure code billed, the primary diagnosis code – Z00.121 or Z00.129 – must be indicated with the diagnosis pointer.
- When patient exams are billed in conjunction with Z00.121 or Z00.129 as the primary diagnosis code, the screening components must have been provided.
- Physicians are strongly encouraged to include all applicable diagnosis codes and procedure codes on the claim for each EPSDT/HealthWatch visit.

[1] *CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Table 1 – CPT Codes for EPSDT Visits

Age	Initial Patient Exam	Established Patient Exam
Less than 1 year	99381	99391
1–4 years	99382	99392
5–11 years	99383	99393
12–17 years	99384	99394
18–20 years	99385	99395

Claims submitted using any patient exam procedure codes listed in Table 1 are billed in conjunction with Z00.121 or Z00.129 as the primary diagnosis code to identify that all EPSDT screening components have been provided. For services that do not qualify as full screening examinations, use the appropriate office visit codes for the services rendered. Appropriate documentation of the services provided or referred must be included in the patient's medical records.

Billing for an EPSDT Visit and Sick Visit (Within the Same Appointment)

When a member presents to a provider for a sick visit, and his or her records indicate the need for an updated EPSDT visit, physicians can include services for both visits and bill **two** visit codes for reimbursement of both services on the same day. Providers must maintain a complete problem-focused visit exam for the presenting problem *and* a complete preventive visit documenting the EPSDT components of the screening exam within the member's health records.

Table 2 – Billing for EPSDT Visit Concurrent with Sick Visit

Visits	CPT Code	ICD Coding	Reimbursement
EPSDT visit plus sick visit (two visit codes)	Preventive visit code (see Table 1) and 99203–99205 or 99213–99215 with modifier 25	Z00.121 or Z00.129 must be used as the primary diagnosis for the preventive visit, and, for the sick visit, use the appropriate diagnosis codes for the presenting problem.	Additional reimbursement for sick visits depends on complexity and doctor/patient relationship (new/established)

If preventive evaluation and management (E/M) procedure codes are used, Z00.121 or Z00.129 should not be used as the primary diagnosis. Providers are allowed to bill an E/M code ***in conjunction*** with an EPSDT visit; however, there are specific billing instructions for billing both procedures.

If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam, the problem-oriented exam can be billed separately, accompanied by the 25 modifier (separate significantly identifiable E/M service). The problem must require additional moderate-level evaluation to qualify as a separate service on the same date. IHCP reimbursement is allowed at the lesser of the submitted charge or the maximum fee for each code; however, the total billed charge must not be more than the provider charges for similar services provided to private-pay patients.

Missed Appointment Procedures

Claim submission for missed appointments is not required. Any claims submitted for missed appointments are used for data gathering only. There is no reimbursement for missed appointments by any IHCP member, whether that member is enrolled in managed care or not.

Members enrolled under Hoosier Healthwise who miss EPSDT/HealthWatch appointments or follow-up appointments must be identified and their names forwarded to the member's MCE or the Hoosier Healthwise Helpline at 1-800-889-9949. Providers should refer all HIP and Hoosier Care Connect members with missed appointments to the appropriate MCE for education. For MCE contact information, see the *IHCP Quick Reference Guide* available at in.gov/medicaid/providers.

Reimbursement for EPSDT/HealthWatch Services

To offer EPSDT/HealthWatch services, the provider must be licensed to perform an unclothed physical exam, as well as other screening components of the EPSDT examination. IHCP-enrolled providers must adhere to screening and documentation procedures to claim the EPSDT/HealthWatch screening reimbursement rate.

Enhanced reimbursement for the initial patient exam is limited to the first EPSDT/HealthWatch screening performed by a screening provider during the participant's lifetime. If additional claims are received for initial screening from the same provider, reimbursement is allowed at the resource-based relative value scale (RBRVS) rate on file for the billed CPT code, not the higher EPSDT/HealthWatch rate.

Initial and established EPSDT exams are reimbursed when submitted with Z00.121 or Z00.129 as the primary diagnosis, and are subject to the 30-office-visits-per-year limitation without prior authorization. Claims submitted with charges other than the designated amounts for screening exams are paid at the EPSDT/HealthWatch rate or the charged amount, whichever is lower. Examinations that do not contain the EPSDT screening components are not considered EPSDT visits and can be billed using the appropriate diagnosis and CPT codes for those visits.

To receive appropriate reimbursement, all procedure codes must be accompanied by a diagnosis code. For an EPSDT visit, screening, or immunization, **diagnosis code Z00.121 or Z00.129 must be used as the primary diagnosis code.**

Third-Party Liability

Federal regulations allow for the bypass of third-party liability (TPL) claim edits when EPSDT/HealthWatch screening procedures are submitted for payment to the IHCP billing contractor (either DXC or an MCE). EPSDT procedure codes are not subject to TPL edits when submitted *in conjunction with* the primary diagnosis code Z00.121 or Z00.129.

Prior Authorization

Prior authorization (PA) is not required for screening services. Individual treatment services may require prior authorization. EPSDT/HealthWatch exams are subject to the 30-office-visits-per-year limitation without PA. For additional information about services that require PA, consult the IHCP Covered Services and Limitations Rule, *405 IAC 5*.

For general information about requesting PA for fee-for-service members, see the *Prior Authorization* module. For authorization of services provided under a managed care program, consult the member's MCE for requirements.

Section 3: History, Measurements, and Physical Examination

Family and Medical History

The history of the patient is an important factor in making a proper assessment of the patient's health. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch screening physician has the responsibility of obtaining a family and medical history as part of the EPSDT screening examination.

This section outlines the categories that should be covered during the history-taking portion of the EPSDT/HealthWatch screening. Modifications should be made that are appropriate for the age and gender of the child. Significant findings should be noted on the child's medical record.

The following is a suggested outline for the health and development history or database:

- Reason for visit
- Identification of caregivers and initial observations of parent, child, and family interactions
- Perinatal history (of child)
  - *Pregnancy*: Prenatal care (including trimester when initiated); habits, including use of drugs, alcohol, or tobacco; illnesses; accidents; hospitalizations; planned or unplanned
  - *Birth*: Description of labor and delivery; anesthesia; complications; location of birth; full term or premature (gestational age of child)
  - *Neonatal*: Condition at birth; measurements; nursery course; length of stay; complications or problems; treatment; breast or bottle fed
- Nutritional status
  - Questions related to feeding or food habits to assess nutritional risk
  - Review the following: height for age and weight for height, laboratory tests, and findings on health history and physical examination
- Developmental history
- Medical history
- Body systems review
- Family health history

  Make a notation of the presence of diseases, such as the following, in maternal and paternal families:
  - Allergy
  - Anemia
  - Arthritis
  - Asthma
  - Cancer
  - Congenital anomalies
  - Cystic fibrosis
  - Diabetes mellitus
  - Emphysema
  - Heart disease
  - Hemoglobin disorder
  - Hereditary or familial conditions

  - Hypertension
  - Kidney disease
  - Mental illness
  - Mental retardation
  - Migraine
  - Obesity
  - Seizures
  - Sexually transmitted disease
  - Stroke
  - Substance use or abuse
  - Tuberculosis
- Psychosocial and lifestyle history
- Child's mental and emotional health
- Family household and environment

Measurements

The following measurements are recommended when performing an EPSDT/HealthWatch exam:

- Height
- Weight
- Weight for length (birth through 18 months)
- Body mass index (BMI) (beginning at 2 years)
- Head circumference (birth through 2 years)
- Blood pressure (from 3 years)

Height, Weight, and Head Circumference

Guidelines for obtaining measurements:

- *Weight is required at each visit for all ages.* Infants and small children should be weighed on a table-model beam scale. Older children who can stand without support can be weighed on a floor-model beam scale. Scales should be balanced prior to weighing and should be checked and adjusted for accuracy according to the manufacturer's specifications.
- *Height is required at each visit for all ages.* Infants and children as old as 2 years old and children with low birth weight, failure to thrive, or certain developmental disorders, or who cannot stand, should be measured supine on a firm surface using a fixed headboard and footboard when possible. For older children who are able to stand without support, use a nonstretchable measuring tape fixed to a true vertical surface.
- Head circumference must be measured at every visit for infants and children through 2 years old.
  - Measure the head with a cloth, steel, or disposable paper tape.
  - Apply the tape around the head from the supraorbital ridges anteriorly to the posterior point (usually the external occipital protuberance) giving the maximum circumference.

See the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) percentile standards. If significant deviation is present, conduct further evaluation and, if necessary, make a referral. These growth charts are available from the CDC NCHS website at cdc.gov.

Blood Pressure

Blood pressure must be checked at every screening visit for all children 3 years of age and older. However, blood pressure can be taken on younger children if a provider decides it is appropriate.

- Take the blood pressure with the appropriately sized pediatric or adult cuff.
- Record the reading in the patient chart.

The American Academy of Pediatrics (AAP) publishes current percentile charts for the normal blood pressure for various ages. Any significant deviation is a basis for further evaluation and, if necessary, referral. See the AAP website at aap.org.

Physical Examination

A complete physical exam must be given each time an EPSDT/HealthWatch screening is performed, with infants totally unclothed and older children undressed and suitably draped. Physicians should always communicate the scope and nature of the physical examination to be performed to the pediatric patient and the parent. This communication should address the use of chaperones and issues of patient comfort, confidentiality, and privacy. The use of a chaperone should be a shared decision between the patient and physician.

Physicians evaluate the following items during a complete physical examination:

- Parent, child, and physician interaction
- General appearance and behavior
- Nutrition and growth
- Skin and hair
- Head
- Face
- Eyes
- Ears
- Nose, mouth, and throat
- Teeth and gums
- Musculoskeletal system
- Neck
- Lymph nodes
- Cardiovascular system
- Respiratory system
- Gastrointestinal system
- Urogenital system
  - For adolescents, a pelvic examination may be done when indicated
- Endocrine system
- Nervous system
- Other

Suspect or positive findings should be summarized and discussed with the parent and child, and a plan of care should be developed.

Section 4: Developmental and Behavioral Health

Developmental and behavioral assessment is to be completed as part of each Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch visit.

Development Surveillance

Developmental surveillance is an ongoing process of observations over time, which must be completed as part of each EPSDT/HealthWatch exam (except for the 9-, 18-, and 30-month visits). The purpose of developmental surveillance is to consistently observe and determine whether a child's acquisition of developmental milestones is progressing within a typical developmental range of achievement according to age and cultural background. Parents should be able to give an accurate history of the child's development; however, a developmental assessment is required. For regular patients, an ongoing recording in the child's chart of developmental milestones may be sufficient to make a judgment about developmental progress.

Children Younger Than 5 Years Old

For children younger than 5 years old, see the Centers for Disease Control and Prevention (CDC) *Developmental Milestones* page at cdc.gov for milestones for motor language and social development. Every child develops at his or her own, unique rate. These milestones are meant to demonstrate typical developmental stages:

- *Motor skills* – Although practice of motor movements has a slight influence on the rate of development, maturation usually plays a much greater role. The newborn infant can perform a number of motor movements mainly of a reflex type.

  Motor development involving the hands tends to proceed along a definite sequential course. The child first looks from the hand to the object, and then attempts to grasp objects with two hands. Grasping with the palm of the hand is learned first, using the ulnar side of the hand initially, and later the radial side. Eventually, grasping with the thumb and index finger is mastered.

- *Social activity and behavior* – Questions should be asked to determine how the child relates to family and peers and whether there is any noticeable deviation in any behavior. Observe for similar behavior in the office.

- *Speech development* – Attention should be paid to the child's speech pattern to see whether it is appropriate for the child's age. Language remains the best predictor of future intellectual endowment and should serve as the common denominator comparing its rate of development with other areas, including gross motor, problem solving, adaptive, and social skills. If a provider decides during the screening process that further evaluation is needed, then one of the standard speech and language tests may be given.

- *Developmental tests* – After observing the child in the various areas of development, the provider may decide that a more in-depth evaluation is needed. The provider can elect to use an objective developmental screening test and receive additional reimbursement. Developmental testing is recommended from 6 months through 4 years old.

If developmental delay is a concern, a referral to First Steps for children birth to 3 years old is recommended. Additional information concerning the First Steps program is located in the *Indiana's First Steps Program* section of this document, or use the following information to contact *First Steps*:

Contact your local First Steps office (select the cluster that serves the county of member's residence)

MS 51
First Steps State Administration
Bureau of Child Development Services
402 W. Washington St., Room W453
Indianapolis, IN 46204-2739

Telephone: 1-800-545-7763
Fax: (317) 234-6701
Email: FirstStepsWeb@fssa.in.gov

Structured Developmental Screening

EPSDT/HealthWatch providers are allowed to bill for a structured developmental screening in addition to an EPSDT screening at the 9-month, 18-month, and 30-month visit. Providers also have the option of conducting the structured developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity, and validity level and are culturally sensitive. The following CPT code, which is limited to two units per date of service (two different screening tools used), may be used when billing for standardized screening:

96110 – *Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

Examples of screening tools allowed for this code include but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire/Social Emotional (ASQ-SE)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II
- Vanderbilt Rating Scales
- Behavior Assessment Scale for Children-Second Edition (BASC-II)

EPSDT/HealthWatch providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

Autism Spectrum Disorder Screening

EPSDT/HealthWatch providers are allowed to bill for a structured autism spectrum disorder screening in addition to an EPSDT screening at the 18-month and 24-month visits. Providers also have the option of conducting the structured developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity, and validity level and are culturally sensitive. The following CPT code, which is limited to two units per date of service (two different screening tools used), may be used when billing for standardized screening:

> 96110 – *Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument*

Examples of screening tools allowed for this code include:

- Checklist for Autism in Toddlers (CHAT)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Screening Tool for Autism in Toddlers and Young Children (STAT)
- Pervasive Developmental Disorders Screening Test-II, Primary Care Screener (PDDST-II PCS)

EPSDT/HealthWatch providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

If screening leads to an autism spectrum disorder diagnosis, a referral for applied behavioral analysis (ABA) therapy is required. See the *Mental Health and Addiction Services* module for PA and billing instructions.

Psychosocial/Behavioral Assessment

The federal EPSDT mandate requires regularly scheduled screenings of all Medicaid-enrolled children to identify physical and mental health problems. To make early identification of behavioral and emotional problems easier and cost-effective for busy physicians, a screening questionnaire can be used as part of routine primary care to facilitate early recognition. Many regularly used tools are available in English and Spanish.

Depression Screening

All adolescents should be screened for depression at each annual EPSDT visit, beginning at the 12-year visit. If a depression screen is positive, further evaluation should be considered. Annual depression screening should be billed with Healthcare Common Procedure Coding System (HCPCS) code G0444 – *Annual depression screening, 15 minutes*.

Tobacco, Alcohol, or Drug Use Assessment

Urine testing to establish drug abuse seems a tempting and objective means of overcoming the problems of denial, unreliable histories, and the less-than-clear-cut signs and symptoms. However, there are problems of sensitivity and specificity in urine screens. False negatives occur because of innocent confounding substances. The physician's role in substance abuse screening, through obtaining a history of the patient, is identification and referral. A verbal assessment for tobacco, alcohol, or drug use should be completed at each annual EPSDT visit beginning at the 11-year visit.

Maternal Depression Screening

It is important for women to understand what postpartum depression is, to know that many women experience similar feelings, and to realize that it should not go untreated. Maternal depression screening should be done at the child's 1-, 2-, 4-, and 6-month EPSDT visit, and it is reimbursable on the child's EPSDT claim, using Current Procedural Terminology (CPT) code 96161 – *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*.

If the screening warrants significant concerns, a referral for treatment should be made to address the mother-child dyad relationship.

This screening and referral option is available to fathers as well.

Section 5: Sensory Screenings – Vision and Hearing

Vision and hearing screenings, either subjective (by history) or objective (by standard testing method), are required at each Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch visit.

Vision Observation and Screening

Undetected vision problems occur in 5%–10% of preschool children. The most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after 5 years old.

Each EPSDT screening must include a visual observation with an external eye examination and routine testing for visual acuity. This visual observation is a component of an EPSDT screening exam and is not separately billable. See Table 3 for timings of required screenings.

Vision referrals must be made when objective screening methods indicate that a referral is warranted.

Table 3 – IHCP Periodicity Schedule for EPSDT/HealthWatch Vision Observation and Screening

Age of Child	Subjective (S) or Objective (O)	Services Required or Recommended
Up to 3 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
3 to 5 years	O	Annual objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.
6, 8, 14, 16, and 20 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
10, 12, and 18 years	O	Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.

External Eye Examination

The external eye examination should include general inspection of the lids and eyeballs, noting prominence, size, and position, as well as growths, inflammations, discharge, or vascular injection. Forward protrusion (exophthalmos) or retraction (enophthalmos) of the globe should be noted.

Abnormalities that cannot be adequately evaluated and treated by the screening physician should be referred to a specialist for further evaluation.

Routine Testing for Visual Acuity

Any marked deviation from the guidelines in Table 4 is a basis for referral to a specialist for further evaluation.

Table 4 – Chronology of Visual Development

Age	Level of Development
Birth	Awareness of light and dark and closes eyelids in bright light.
Neonatal	Rudimentary fixation on near object (3 to 30 inches).
2 weeks	Transition fixation, usually monocular, at a distance of roughly three feet.
4 weeks	Follows large, conspicuously moving objects.
6 weeks	Moving objects evoke binocular fixation briefly.
8 weeks	Follows moving objects with jerky eye movements. Convergence beginning to appear.
12 weeks	Visual following now a combination of head and eye movements and convergence improving. Enjoys light objects and bright colors.
16 weeks	Inspects own hands. Fixates immediately on a 1-inch cube brought within 1 to 2 feet of eye. Vision 20/300 to 20/200 (6/100 to 6/70)
20 weeks	Accommodative convergence reflexes all organizing. Visually peruse lost rattle. Shows interest in stimuli more than 3 feet away.
24 weeks	Retrieves a dropped 1-inch cube, can maintain voluntary fixation of stationary object even in the presence of competing moving stimulus, and hand-eye coordination appearing.
26 weeks	Will fixate on a string.
28 weeks	Binocular fixation clearly established.
36 weeks	Beginning of depth perception.
40 weeks	Marked interest in tiny objects and tilts head backward to gaze up. Vision 20/200 (6/70)
52 weeks	Fusion beginning to appear. Discriminate simple geometric forms (squares and circles). Vision 20/180 (6/60)
12–18 months	Looks at pictures with interest.
18 months	Convergence well established and localization of distance is crude − runs into large objects.
2 years	Accommodation well developed. Vision 20/40 (6/12)
3 years	Convergence smooth and fusion improving. Vision 20/30 (6/9)
4 years	Vision 20/20 (6/6)
Note: *Adapted from Seidel's Guide to Physical Examination, 8th Ed., Mosby, an imprint of Elsevier Inc., 2015. Ball, Jane W., Dains, Joye E., Flynn, John A., Solomon, Barry S., Stewart, Rosalyn W.*	

Visual Acuity – Infants

Visual acuity is difficult to evaluate in infants. Providers should observe whether an infant follows a light or a bright attractive toy in different directions of gaze. Each eye should be tested separately. If the infant fails to respond to such testing, the provider should observe the pupillary responses for reaction to direct light stimulus.

Infants can be tested by alternately covering each eye. If visual acuity is poor in one eye, the infant resists actively when the good eye is covered and vision is disturbed, but is much less affected when the eye with decreased vision is covered.

Visual Acuity – Children 36–59 Months

The most direct way to detect amblyopia (monocular decreased vision) in 3- and 4-year-old children is to assess monocular visual acuity. Recommended tests include Lea symbols, or tumbling E charts, because they allow screening of younger children. Isolated optotypes with surround bars are also acceptable. Stereopsis testing is recommended to detect strabismus as an amblyopiogenic factor.

Vision Referral Standards

Referrals to an appropriate eye or vision specialist must be made when objective screening methods indicate that a referral is warranted. A child may also be referred if parental complaints warrant a referral. Children failing a test for hyperopia can be referred for additional diagnosis and treatment.

Screening results from school should be documented in the patient's record. Vision screens should be completed within the public schools as a requirement of the Indiana Department of Education in grades 1, 3, and 8. Parents may be able to share results, which may include a formal referral for additional testing.

Vision Testing

Testing procedures and passing criteria for commercially available vision tests should be followed as advised in the American Academy of Pediatrics (AAP) publication, *Procedures for the Evaluation of the Visual System by Pediatricians* at pediatrics.aappublications.org. In the online publication, see *Table 1 – Eye Examination Guidelines* (pages 6–7) and *Table 2 – Amblyopia Risk Factor Targets Recommended by the American Association for Pediatric Ophthalmology and Strabismus* (page 7).

Hearing Observation and Screening

The AAP supports the goal of universal detection of hearing loss in infants before 3 months of age, with appropriate intervention no later than 6 months of age. Universal detection of hearing loss requires universal screening of all infants. Screening tests that vary according to age must be part of the EPSDT/HealthWatch screening.

The most critical period for learning language is during the first 2 years of life. If hearing problems are not detected until after this time, lost ground in language development may never fully be regained. The early detection of hearing loss is an urgent duty of any physician caring for young children.

Newborn Hearing Screening

Indiana legislation mandates that every infant must be given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments:

- Newborns must be screened at the birth hospital before the infant is discharged. The IHCP does not allow hospitals to bill separately for initial newborn screening.
- Providers that deliver, at locations *other than in the hospital*, newborns that are not hospitalized at birth may use the appropriate Current Procedural Terminology (CPT) codes to bill for the newborn hearing screening.

Newborns that do not pass the newborn hearing screen should have their hearing evaluated by an audiologist as soon as possible. This evaluation is done to determine how a baby is hearing, as well as look for possible causes of hearing loss.

> *Note: The universal newborn hearing screening (UNHS) is designed to identify infants with hearing deficits, ensure appropriate follow-up intervention, and collect information on the evidence of hearing loss. When the UNHS identifies a newborn with a possible hearing deficit, the Indiana State Department of Health (ISDH) Early Hearing Detection and Intervention (EHDI) program follows up to encourage further diagnostic testing. For further information, see the Early Hearing Detection and Intervention (EHDI) Program page at in.gov/isdh.*

For any follow-up diagnostic testing resulting from detection of possible hearing impairment during the newborn screening process, providers should bill the same way they bill other audiological testing. Providers should obtain PA, if applicable.

Diagnostic testing uses the automated auditory brainstem test and other tests to determine how a baby hears. The tests can be done at various loudness levels and at different pitches (high sounds and low sounds). If testing is done before 3 months of age, the tests can usually be completed while the baby sleeps. For older or more active babies, medicine may be needed to help the baby sleep during the tests. It is important for babies to be quiet and not move much during testing, so the results of the diagnostic testing are accurate.

Infant Hearing Screening

Noisemakers can be used to screen an infant's hearing. High frequencies can be tested with a squeaky toy or small bell, and middle frequencies with a rattle or piece of tissue paper. While the infant is distracted with a visual stimulus, such as a toy or brightly colored object, the noisemaker is sounded outside the field of vision. Normal responses are as follows:

- At 4 months, there is a widening of the eyes, a cessation of previous activity, and possibly a slight turning of the head in the direction of the sound.
- At 9 months or older, the child should usually be able to locate sound, whether it comes from above or below.

Many hearing tests, such as banging pots together or hearing a low-flying airplane, can falsely give normal results. Most children with significant hearing deficits have residual hearing and respond to very loud noises. However, they are educationally and socially deaf if they cannot hear normal speech sounds.

Hearing Screening of Older Children

At age 3 years, a child can begin to be tested with a pure tone audiometer. However, EPSDT/HealthWatch does not require an audiometric screening until the child reaches 4 years old. If the child is unable to cooperate, the test can be deferred until the next exam. Deferral due to inability to cooperate should be documented in the patient record.

Hearing screening must be done with an audiometer or audioscope. Providers that do not wish to perform the objective hearing screen can refer the child to an audiologist for screening.

Hearing screening should be completed within the public schools as a requirement of the Indiana Department of Education in grades 1, 4, 7, and 10. Some schools also test kindergarten children. These screening efforts should not be duplicated unless the child is at risk and the situation warrants rescreening. Screening results from the school should be documented in the patient's medical records. Parents may be able to share results, which may include a formal referral for additional testing.

See Table 5 for timing of required screenings.

Table 5 – IHCP Periodicity Schedule for EPSDT/HealthWatch
Hearing Observation and Screening

Age of Child	Subjective (S), Objective (O), or Required (R)	Services Required or Recommended
Newborn	R	Newborn hearing screening via fully automated auditory brain stem response, if available. *Note: All patients are to be screened at this time.*
Under 12 months	S	Subjective screening, by history and/or other infant screening techniques; refer child to an appropriate hearing specialist, if warranted.
12 months through 3 years	O	As early as possible, perform an objective screening using a standard testing method. Refer those at risk or suspected of hearing deficit to an appropriate specialist.
4 to 5 years	R	Audiometric screening with an audiometer or audioscope (child may be referred to an audiologist for screening); refer child at risk or suspected of hearing deficit to an appropriate specialist.
6, 8, 14, 16, and 20 years	S	Subjective screening by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.
10, 12, and 18 years	O	Objective hearing screening by a standard testing method (hearing tests are given by the Indiana Department of Education in grades 1, 4, 7, and 10 – several schools also test kindergarten students). **Do not duplicate school screenings unless the child is considered at risk and rescreening is warranted.**

See the *Audiological High Risk Register* section for categories of patients often associated with unsuspected hearing loss.

Referral Standards

When a chronic hearing deficit is suspected or has been confirmed, an appropriate referral should be arranged to do precise testing. If the hearing deficit is confirmed, the patient should be referred to an otolaryngologist for examination in an attempt to determine what treatment may be necessary.

Audiological High Risk Register

The following are considered audiological high risk register (HRR):

- Neonates (birth to 28 days) who fall into one or more of the 10 risk criteria identified by the Joint Committee on Infant Hearing (1990) are considered at risk for hearing impairment and should receive audiologic screening. The factors frequently referred to as the HRR are:
  - Family history of congenital or delayed onset childhood sensorineural impairment
  - Congenital infection known or suspected to be associated with sensorineural hearing impairment such as toxoplasmosis, syphilis, rubella, cytomegalovirus, and herpes
  - Craniofacial anomalies, including morphologic abnormalities of the pinna and ear canal, absent philtrum, low hairline, and so forth

  - Birth weight less than 1,500 grams (less than 3.3 pounds)
  - Hyperbilirubinemia at a level exceeding indication for exchange transfusion
  - Ototoxic medications, including but not limited to:
    - Aminoglycosides, used for more than 5 days (such as, gentamicin, tobramycin, kanamycin, streptomycin)
    - Loop diuretics used in combination with aminoglycosides
  - Bacterial meningitis
  - Severe depression at birth, which may include infants with Appearance, Pulse, Grimace, Activity, Respiration (APGAR) scores of 0–3 by 5 minutes or those who fail to initiate spontaneous respiration by 10 minutes or those with hypotonia persisting to 2 hours of age
  - Prolonged mechanical ventilation for a duration equal to or greater than 10 days, such as persistent pulmonary hypertension
  - Stigmata or other findings associated with a syndrome to include sensorineural hearing loss, such as Wardenburg or Usher's Syndrome

- Infants (29 days to 2 years)
  - Parent or caregiver concerns about hearing, speech, or developmental delay
  - Bacterial meningitis
  - Neonatal risk factors that may be associated with progressive sensorineural hearing loss, such as cytomegalovirus, prolonged mechanical ventilation, and inherited disorders
  - Head trauma, especially with either longitudinal or transverse fracture of the temporal bone
  - Stigmata or other findings associated with syndromes known to include sensorineural hearing loss, such as Wardenburg or Usher's Syndrome
  - Ototoxic medications including, but not limited to, the aminoglycosides used for more than 5 days, such as gentamicin, tobramycin, kanamycin, streptomycin, and loop diuretics used in combination with aminoglycosides
  - Neurodegenerative disorders such as neurofibromatosis, myoclonic epilepsy, Freldrich's Ataxia, Huntington's Chorea, Werdnig-Hoffman Disease, Tay-Sach's Disease, Charcot-Marie Tooth Disease, any metachromatic leukodystrophy, or any infantile demyelinating neuropathy

- Screening test failures
  - Infants who fail any of the office screening tests described previously should be given more sensitive tests to clarify hearing status.

- Suggestive symptoms in infants
  - Concerned parents – Most parents of deaf children have some suspicion of the problem by the time the child is 6 months old and sometimes earlier. When the parent suspects hearing impairment, a reliable hearing test should be given.
  - Not awakening to sound – A normal sleeping infant sometimes awakens to sounds in other parts of the house. If this behavior has not been observed, the parent should be asked to be alert for it and to report observations at the next EPSDT/HealthWatch visit. If it does not occur, the child requires referral.

- Speech delays
  - Before any child is labeled as having intellectual disability, autism, auditory agnosia, or a developmental speech delay, a valid hearing test is required. Verbal communication depends on hearing. If the patient is old enough to cooperate with pure tone audiometry and the results are normal, referral to an audiologist is not needed. Referral to an audiologist should be preceded by otoscopic examination.

Section 6: Procedures, Lab Tests, and Immunizations

Providers must provide or arrange for all the appropriate Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch services for each child at each age level in a timely manner, and properly document and bill the services. The Indiana Health Coverage Programs (IHCP) and managed care entities (MCEs) closely monitor all claims submitted to ensure that appropriate procedures are provided and to give the provider feedback concerning age-specific Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org.

Newborn Screening

> *Note: For information about newborn **hearing** screening, see the Newborn Hearing Screening section.*

Newborn screenings are to be given at the earliest feasible time for the detection of the following disorders:

- Biotinidase deficiency
- Critical congenital heart disease (CCHD)
  - A pulse oximetry screen for CCHD should be performed after 24 hours of birth and before discharge from hospital, in accordance with AAP guidelines.
- Cystic fibrosis
- Endocrine disorders, including congenital adrenal hyperplasia (CAH) and hypothyroidism
- Galactosemia
- Hemoglobinopathies, including sickle cell anemia

> *Note: Early detection of sickle cell is important because oral prophylactic penicillin should be started by 2 months old to prevent life-threatening infections. See the Immunizations section for special immunization information for children with sickle cell.*

- Metabolic conditions, including approximately 40 amino acid disorders, fatty acid oxidation disorders, and organic acidemias, such as:
  - Homocystinuria
  - Maple syrup urine disease
  - Phenylketonuria (PKU)
  - Medium chain acyl-coenzyme A dehydrogenase (MCAD) deficiency
- Severe combined immunodeficiency (SCID)
- Spinal muscular atrophy (SMA)
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
  - Tandem mass spectrometry
  - High performance liquid chromatography
  - Isoelectric focusing
  - Time resolved fluoroimmunoassay: immunoreactive trypsinogen (IRT) measurement
  - DNA mutation analysis

See the Indiana State Department of Health (ISDH) *Newborn Screening* web page at in.gov/isdh for general information about the newborn screening program.

Billing and Reimbursement

Reimbursement for the newborn screening is included in the diagnosis-related group (DRG) that the IHCP pays for the newborn hospitalization, as described in the *Inpatient Hospital Services* module. The IHCP does not require EPSDT/HealthWatch providers to report newborn screening on the professional claim (*CMS-1500* claim form or electronic equivalent).

Submitting Blood Samples

Under contract with the ISDH, blood samples for the newborn screening are sent to Indiana University (IU) Laboratory. See the *Inpatient Hospital Services* module for information about newborn screening blood sample collection and submission.

Reviewing and Reporting Results

Newborn screening results must be recorded in the patient record for infants younger than 1 year old. Providers must determine whether valid newborn screening test results have been obtained for the infant. If a valid test has been obtained for the infant and the test results were normal, no further testing is required. The newborn screening process is complete.

For information about registering for online access to the newborn screening results, see the *Indiana Newborn Screening Tracking & Education Program (INSTEP)* web page at in.gov/isdh.

The Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant, and child health. It is every physician's responsibility to report to the IBDPR using the Physicians Reporting Tool. Conditions reported to IBDPR are both reportable and targeted; reportable conditions are mandated by law. See the *IBDPR-Indiana Birth Defects and Problems Registry* web page at in.gov/isdh for details.

Rescreenings and Second Screenings

If a rescreening is needed because the first screening was invalid, additional testing of serums is needed because test results were abnormal, or there is no record that newborn screening was done, providers should call ISDH to work out the best method of accomplishing newborn screening. Generally, the ISDH recommends that the infant be taken back to the birth hospital to have that hospital perform newborn screening or rescreening; however, providers should consult with the ISDH on how best to proceed with newborn screening when there is an invalid or abnormal test. If additional information is needed, contact the following:

Genomics and Newborn Screening Program
Indiana State Department of Health
2 N. Meridian St., 2E
Indianapolis, IN 46204

Telephone: 1-888-815-0006
Fax: (317) 234-2995
Email: ISDHNBS@isdh.IN.gov

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Because newborns can be released from hospitals prior to the 48 hours needed to obtain valid newborn screening results, an increasing number of newborns require a second screening. Families are generally asked to bring the newborn back to the birth hospital as an outpatient, or the hospital requests that a nurse make a follow-up visit to obtain the sample for newborn screening. In either case, the hospital could potentially bill the IHCP separately for newborn screening, even though reimbursement for these services is included in the DRG for the newborn hospitalization. However, separate reimbursement will not be made for these services, even when billed separately.

There are occasions when hospitals are requested to perform newborn screening for newborns born in *another* Indiana hospital. For example, when distance precludes a trip to the birth hospital, the infant should be taken to the nearest hospital with birthing facilities so that newborn screening can be completed. To prevent the second hospital from being charged by the IU Laboratory for the second screen, the hospital must indicate on the filter paper card, in the space provided, the name of the birth hospital and the submitting hospital. The IU Laboratory attempts to match the infant's second screen with the first screen so that the hospital is not charged. If the infant's name or birth date has been changed, the original name and date of birth must be included in the information sent to the IU Laboratory to facilitate a match.

Immunizations

Immunizations should be provided or arranged for each child according to the schedule recommended by the AAP. Every EPSDT/HealthWatch visit should be an opportunity to update and complete a child's immunizations.

Note:	*Children with sickle cell should be immunized as recommended by the AAP immunization schedule. They should also receive pneumococcal vaccine at 2 years old.*

The federal Vaccines for Children (VFC) program makes available, at no cost to providers, certain vaccines for administration to IHCP members 18 years old and younger. If an EPSDT/HealthWatch provider chooses not to participate in the VFC program, the provider must document the IHCP-enrolled patient's immunization history.

See the Centers for Disease Control (CDC) Vaccine Price List at cdc.gov for information on what vaccines are covered under the VFC program. For more information about the VFC program, see the *Vaccines for Children* page at in.gov/isdh and the *Injections, Vaccines, and Other Physician-Administered Drugs* module.

Blood Lead Screening

Screening for blood lead toxicity for all children enrolled in Medicaid is a federal requirement. The Family and Social Services Administration (FSSA) requires that all children enrolled under Medicaid receive a blood lead screening test between 9 months and 12 months and again at 24 months of age. If the member is at high risk for lead exposure (see the *Verbal Risk Assessment* section), the initial screening should be performed at the 6-month visit and repeated at the 12-month and 24-month visits. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

A blood lead test result equal to or greater than 5 µg/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. Subsequent follow-up testing is required for children with blood lead levels equal to or greater than 5 µg/dl. See the *Interpretation of Blood Lead Test Results and Follow-Up Activities* section for schedules.

Note:	*The lead exposure diagnosis code (Z77.011) should only be used after a child has been diagnosed as lead exposed. See the Billing for Blood Lead Testing Services section for details.*

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning in Indiana children. Providers are required to report *all* results of blood lead screenings to the ISDH no later than 1 week after completing the examination. The ILHHP provides medical and environmental case management follow-up for children who are identified with elevated levels of lead in their blood.

Children from 6 months through 6 years of age are at greatest risk for elevated blood lead levels. The ILHPP has identified the following four steps to a successful lead poisoning prevention program:

1. Early identification of children with excessive lead absorption through screening programs
2. Treatment of children with abnormal blood lead levels
3. Prompt termination of further excessive lead exposure (environmental investigation and abatement)
4. Intensive parent and public education about lead poisoning (see the *Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger* section)

Verbal Risk Assessment

The following questions should be asked at each EPSDT visit:

- Is your child living in or regularly visiting (or has your child previously lived in or regularly visited) a house or child care center built before 1978?
- Does your child have a sibling or playmate who has, or who has had, lead poisoning?
- Does your child frequently come in contact with an adult who works in an industry using lead (for example, a battery factory, steel smelter, or radiator shop) or who has a hobby using lead (such as stained glass, fishing, or reloading ammunition)?
- Is your child a recent immigrant from a country where the use of lead in consumer products is not restricted?
- Is your child a member of a minority group?
- Has your child been exposed to traditional remedies that may contain lead (such as Arzacon or Greta) or traditional cosmetics that main contain lead (such as kohl)?

If the answer to any question is positive, a child is considered at high risk for high doses of lead exposure, and a blood lead level test should be performed at the 6-month visit and repeated at the 12-month and 24-month visits.

Subsequent verbal risk assessments can change a child's risk category. If, as a result of a verbal risk assessment, a previously low-risk child is recategorized as high-risk, that child must be given a blood lead level test.

The following items place a child at risk for lead poisoning:

- Painted household surfaces such as cribs, window sills, toys, doors, radiators, or fallen paint chips, flaking areas, and holes in the walls
- Lead water pipes
- Soil, dirt, and dust inside and outside a dwelling
- Imported brands of plastic mini-blinds
- Paper, newsprint, magazine pages, and metallic wrapping paper
- Playground equipment with chipped lead-based paint
- Water wells

- Industrial crayons, batteries, rubber, electronic devices, printed material (yellow and orange inks or oil colors may contain lead chromate), cans, varnishes, shellac, and paints on containers
- Unglazed food containers or pottery that have been lead glazed, lead alloyed, plated, or soldered
- Fungicides, insecticides, cosmetics, and various medications, which can contain lead carbonate
- Cigarette butts, decorative candle wicks, and matches, which can contain lead acetate
- Burning painted lumber and battery casings, which can place lead in the air
- Folk remedies such as greta and azarcon (used to treat diarrhea or gastrointestinal upset), which can contain substantial amounts of lead

Procedures for Sending Blood Samples for Lead Testing

The FSSA recommends that blood samples for lead screening be sent to the ISDH Laboratories to ensure that testing is done on atomic absorption spectrophotometers (AAS) and to ensure that the results are known to the ILHPP.

The ISDH provides filter paper cards, postage-paid business reply envelopes, and venous mailing tubes at no charge to health care providers for specimen collection and transport in support of the Maternal and Child Health Program. Providers should call the ILHPP at (317) 233-1250 or email lead@isdh.in.gov to register. See the *ISDH Blood Lead* page at in.gov/isdh for additional details.

Filter paper card specimens can be mailed to the lab in the provided postage-paid, preprinted envelopes. Venous blood samples should be sent in the venous mailing tubes to:

ISDH Laboratories
Blood Lead Lab
550 W. 16th St., Ste. B
Indianapolis, IN 46202

When forwarding blood samples to ISDH/ILHPP, primary medical providers (PMPs) must include their NPI and authorization code for members on the paperwork accompanying the sample. If the member is enrolled in a managed care program, include the MCE PMP authorization and referral information.

Billing for Blood Lead Testing Services

When a venous blood sample is required, providers can bill procedure code 36415 – *Collection of venous blood by venipuncture* to indicate that a blood draw was made. A distinction must be made by diagnosis code to differentiate between individuals being tested to confirm a high fingerstick result and those that have been diagnosed with or are being treated for lead poisoning. When a follow-up blood lead test is performed, subsequent to the confirmation test, ICD-10 diagnosis code **Z77.011 – *Contact with and (suspected) exposure to lead*** should be used in addition to the primary EPSDT diagnosis code of Z00.121 or Z00.129.

Providers that use the ILHPP's postage-paid kit cannot bill the IHCP a handling and/or conveyance fee for conveying samples to the lab. Providers that send blood samples to private labs for testing should use the following codes if the provider incurs an expense associated with the conveyance:

- 99000 – *Handling and/or conveyance of specimen for transfer from the office to a laboratory*
- 99001 – *Handling and/or conveyance of specimen for transfer from the patient in other than office to a laboratory (Distance may be indicated)*

The coverage and reimbursement rate for CPT code 83655 – *Lead, quantitative, blood* is expanded to include tests administered using filter paper (U1 modifier) and handheld testing devices (U2 modifier) in the office setting.

Interpretation of Blood Lead Test Results and Follow-Up Activities

Interpretation of blood lead test results and follow-up activities are grouped into different classes. See Tables 6, 7, and 8 and CDC recommended guidance at cdc.gov on actions, receiving confirmatory samples, and follow-up testing.

Table 6 – Recommended Actions Based on Blood Lead Level

Class	Blood Lead Concentration (µg/dl)	Comment
I	< 5	A child in Class I is not considered to be lead-poisoned.
II	5–44	A child in Class II may need to be rescreened more frequently. A child in Class II should receive nutritional and educational intervention and be rescreened within 1 month. A child in Class II should receive environmental evaluation, remediation, and a medical evaluation and neurodevelopmental monitoring. If the blood lead level persists in this range, environmental investigation and intervention should be done. A child in this class may need pharmacologic treatment of lead poisoning. Rescreen the child within 1 week to 1 month with higher level being more urgent need for confirmatory testing.
III	45–69	A child in Class IV will need both medical and environmental interventions, including chelation therapy within 48 hours.
IV	≥ 70	A child with Class V lead poisoning is a **medical emergency**. Medical and environmental management must begin **immediately**.

Table 7 – Recommended Schedule for Obtaining a Confirmatory Venous Sample

Blood µg/dl	Time to Confirmation Testing
5–9	1–3 months
10–44	1 week – 1 month *
45–59	48 hours
60–69	24 hours
≥ 70	Urgently as emergency test

* *The higher the blood lead level on the screening test, the more urgent the need for confirmatory testing.*

Note: Adapted from: Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials. Atlanta: 5 CDC; 1997.

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Table 8 – Schedule for Follow-Up Blood Lead Testing*

Venous Blood Lead Level µg/dl	Early Follow-Up Testing (2–4 Tests after Identification)	Later Follow-Up Testing after Blood Lead Level Declining
5–9	3 months **	6–9 months
10–19	1–3 months **	3–6 months
20–24	1–3 months **	1–3 months
25–44	2 weeks – 1 month	1 month
≥ 45	As soon as possible	As soon as possible

* *Seasonal variation of blood lead levels exists and may be more apparent in colder climate areas. Greater exposure in the summer months may necessitate more frequent follow-ups.*

** *Some case managers or primary care physicians may choose to repeat blood lead tests on all new patients within a month to ensure that their blood lead level is not rising more quickly than anticipated.*

Comprehensive Environmental Lead Testing

The IHCP cover initial and follow-up comprehensive environmental lead investigation services for IHCP members with a confirmed elevated blood lead level (EBLL). EBLL is defined by the CDC as a blood level of 5 µg/dl or higher.

Services are limited to one unit per member per 12-month period. Prior authorization is not required for initial or follow-up comprehensive environmental lead testing.

Hematocrit or Hemoglobin Testing for Iron Deficiency Anemia

The purpose of screening for anemia is to uncover correctable nutritional anemia, such as iron deficiency anemia. Providers should follow current clinical standards for diagnosis of anemia based upon age of the child.

Dyslipidemia Screening

Dyslipidemia screening should be done once during each of these age-range visits:

- Between the 9-year and 11-year visits
- Between 17-year and 21-year visits

In accordance with *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, EPSDT providers should obtain a fasting lipoprotein profile (total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, and triglyceride) before onset of puberty and in late adolescence. If a history of familial hypercholesterolemia is identified, screening of younger children should be considered.

Tuberculosis Testing

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that all routine pediatric healthcare evaluations include assessment of risk of exposure to tuberculosis.

Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. For children who receive a tuberculosis assessment that results in a skin test, use ICD-10 diagnosis code Z20.1 – *Contact with and (suspected) exposure to tuberculosis.*

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed in the following paragraphs. Routine tuberculin skin testing of children with no risk factors and residing in low-prevalence communities is not indicated.

Children for whom immediate skin testing is indicated:

- Children with contacts to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last 5 years
- Children with radiographic or clinical findings suggesting tuberculosis
- Children immigrating from endemic areas, such as Asia, Africa, the Middle East, and Latin America
- Children with travel histories to endemic countries or significant contact with indigenous persons from such countries

Children who should be tested annually for tuberculosis:

- Children infected with human immunodeficiency virus (HIV)
- Incarcerated adolescents

> *Note: Children infected with HIV should have a tuberculin skin test or an Interferon-Gamma Release Assay (IGRA) blood test. Tuberculin skin test is preferred over IGRAs for children under 5 years old.*

Children who should be tested every 2 to 3 years:

- Children exposed to the following individuals who are HIV-infected: homeless residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers

Children who have no risk factors but who reside in high-prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin skin testing at 4 to 6 years old and 11 to 16 years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of healthcare workers are not at increased risk of acquiring tuberculosis infection unless the workers' tuberculin skin test results convert to positive or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of 5, 10, and 15mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures, and preventive therapy.

STD and STI Screening

All sexually active adolescents must be considered at high risk for most sexually transmitted diseases (STDs) and sexually transmitted infections (STIs).

The most sensitive and specific tests for chlamydia and gonorrhea are those involving deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) amplification (ligase chain reaction [LCR] and polymerase chain reaction [PCR]). Informed consent must be obtained from the individual. Culture of urine for these organisms is unsatisfactory. Antigen detection (Enzyme-Linked ImmunoSorbent Assay [ELISA] or direct fluorescent antibody) for chlamydia or gonorrhea is less sensitive than other methods.

Asymptomatic pyuria (white blood cells in urine) can be detected using dipsticks for leukocyte esterase. Among sexually active adolescents, the likelihood of infection with an STD or STI is increased when leukocyte esterase is detected. Subsequent evaluation to identify the etiology of the pyuria is indicated. Chlamydia urethritis must be considered when leukocyte esterase is identified in the urine of adolescent males.

HIV Testing

HIV testing should be completed once between the 15-year and 18-year visits.

Common HIV tests use protein products of the virus to detect antibodies produced by the infected host. The two antibody tests used most commonly are Enzyme-Linked ImmunoSorbent Assay (ELISA) and Western Blot.

These tests are not 100% sensitive and require the production of antibody by the host and the absence of cross-reaching antibodies. Newer methodologies have been developed to divide HIV-1 tests into several groups:

- Virus culture techniques
  - Peripheral blood mononuclear cells (PBMC) co-culture for HIV-1 isolation
  - Quantitative cell culture
  - Quantitative plasma culture
- Antibody detection tests
- Antigen detection tests
- Viral genome amplification tests
- Immune function tests

False positive ELISA reactions generally result from cross-reaching antibodies, such as those against class II human leukocyte antigens that are most often observed in multiparous women or in a person who has received multiple units of transfused blood. A common misconception is that a false positive ELISA will always be corrected by the confirmatory Western Blot test.

The most important parameter when interpreting HIV tests is the positive predictive value. The probability of a positive test result occurring in a truly infected individual is critically dependent on the prevalence of HIV infection of the population tested. In testing HIV drug users from a major U.S. city in which the seroprevalence is 50%, the positive predictive value would approach 100%. Conversely, in screening female schoolteachers from a rural area where the seroprevalence is 0.01%, 50% of the women testing positive would have a false positive result. The likelihood of two false negative tests (ELISA and Western Blot) is very low, even in areas where seroprevalence is low.

Section 7: Oral Health – Risk Assessment, Referral, and Preventive Dental Care

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch providers are required to perform oral health risk assessments and make referrals for dental services as indicated on the Bright Futures/American Academy of Pediatrics (AAP) periodicity schedule at aap.org

Preventative Fluoride Care

EPSDT providers should recommend brushing with fluoride toothpaste in the proper dosage for the child's age. After teeth are present, fluoride varnish may be applied every 3–6 months, in either the primary care or dental office.

> *Note: Reimbursement for physician-administered topical fluoride varnish is available from first tooth eruption until the age of 4; for more information see the Dental Services module.*

If the child's primary water source is deficient in fluoride, providers should consider oral fluoride supplementation for the 12-, 18-, 24-, and 30-month visits, as well as at yearly visits for ages 3–16.

Dental Exam Recommendations

Children should visit a dentist as early as the first tooth eruption and no later than 12 months of age. The first examination by a dentist can reveal decay, unerupted or missing teeth, and the need for prophylaxis or treatment. Dental visits for preventive care for should continue every 6 months after the first visit.

Table 9 shows recommendations for pediatric dental examinations.

Table 9 – IHCP EPSDT Dental Periodicity Schedule, Adapted from the American Academy of Pediatric Dentistry (AAPD)

	6–12 months	12–24 months	2–6 years	6–12 years	>12 years
Clinical oral examination[1,2] to include:	■	■	■	■	■
Assess oral growth and development[3]	■	■	■	■	■
Caries-risk assessment[4]	■	■	■	■	■
Anticipatory guidance/counseling[6]	■	■	■	■	■
Injury prevention counseling[7]	■	■	■	■	■
Counseling for nonnutritive habits[8]	■	■	■	■	■
Counseling for speech/language development	■	■	■		
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
Assessment for pit and fissure sealants[9]			■	■	■
Transition to adult dental care					■
Radiographic assessment[5]	■	■	■	■	■

	6–12 months	12–24 months	2–6 years	6–12 years	>12 years
Prophylaxis and topical fluoride[4,5]	■	■	■	■	■
Assessment and treatment of developing malocclusion			■	■	■
Assessment and/or removal of third molars					■

[1] *First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.*

[2] *Includes assessment of pathology and injuries.*

[3] *By clinical examination.*

[4] *Must be repeated regularly and frequently to maximize effectiveness.*

[5] *Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.*

[6] *Appropriate discussion and counseling should be an integral part of each visit for care.*

[7] *Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards.*

[8] *At first, discuss the need for additional sucking: digits versus pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.*

[9] *For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.*

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Section 8: Health Education and Anticipatory Guidance

Health education, including anticipatory guidance, is a required component of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. At the outset, the physical or dental screening provides the initial context for providing health education. Health education and counseling to parents or guardians and to children is required and is designed to assist in understanding what to expect in terms of the child's development. Health education provides information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

The *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* at brightfutures.aap.org outlines sample questions for each visit under the EPSDT schedule, to address the expert panel's anticipatory guidance priorities for early childhood, middle childhood, and adolescence. The intention of this resource is to invite discussion, gather information, address needs and concerns, and build a partnership with each family member.

At each screening visit, provide age-appropriate education and guidance concerning such topics as the following:

- Auto safety – Car seats, seat belts, air bags, positioning young or lightweight children in the backseat
- Recreational safety – Helmets and protective padding, playground equipment
- Home hazards – Poisons, accidental drowning, weapons, matches and lighters, staying at home alone, use of detectors for smoke, radon gas, and carbon monoxide
- Exposure to sun and secondhand smoke
- Alcohol and tobacco use
- Substance abuse
- Adequate sleep
- Exercise and nutrition, including eating habits and disorders
- Sexual activity
- Peer pressure
- Immunization and blood testing as required

Dental Health Education for Parents

Among the many dental conditions affecting children, dental caries (tooth decay) is the preeminent concern in the context of Medicaid services because of its substantial prevalence in the low-income population. Tooth decay continues to be the single most common chronic disease among U.S. children, despite the fact that it is highly preventable through early and sustained home care and regular professional preventive services.

Parents should be counseled on the importance of taking care of their babies' teeth. Teeth are susceptible to decay as soon as they appear in the mouth. Teeth can be brushed as soon as they appear.

Printed information about baby bottle tooth decay is available from the Indiana State Department of Health (ISDH):

Oral Health
Indiana State Department of Health
2 N. Meridian St., Section 7G
Indianapolis, IN 46204

Email: oralhealth@isdh.state.in.us
Website: in.gov/isdh/18717.htm
MOMS Helpline: 1-844-MCH-MOMS (1-844-624-6667)

Dental caries are generally considered to be reversible or capable of being arrested in the earliest stages through a variety of proven interventions. Beyond the early stages, the decay process generally tends to advance and become more difficult and costly to repair the longer it remains untreated. Therefore, treatment initiated early in the course of dental caries development will almost always be easier for both child and dentist, less expensive, and more successful than treatment begun at a later time.

Dental care is one of the most commonly unmet treatment needs in children. Lower-income children have more untreated dental disease than more affluent children who obtain care on a regular periodic basis. Reasons for this disparity include the fact that low-income children are more likely to experience dental disease and frequently only access care on an episodic or urgent basis when decayed teeth cause pain or swelling.

It is generally recommended by the American Academy of Pediatric Dentistry (AAPD) that children receive dental care at 6-month intervals or as indicated by the patient's needs or risk for disease. See the *Oral Health – Risk Assessment, Referral, and Preventive Dental Care* section of this document for detailed recommendations regarding the periodicity of professional dental services for children.

Education Regarding Lead Poisoning for Pregnant Women and Children 6 Years Old or Younger

Lead poisoning is preventable. The key to successful prevention is to educate parents with young children about the potential sources of lead poisoning. For a list of lead education publications, available in both English and Spanish, that providers can make available in their offices, see the ISDH Lead and Healthy Homes Division *Publications* page at in.gov/isdh. Contact the Indiana Lead and Healthy Homes Program (ILHHP) at (317) 233-1250 for ordering information.

For additional resources, see the *Lead and Healthy Homes Program* page at in.gov/isdh.

Referrals to Other Healthcare Programs

The following sections provide information about two other programs that may provide healthcare coverage or services for eligible children, in addition to Indiana Health Coverage Programs (IHCP) EPSDT/HealthWatch.

Children's Special Health Care Services

Children's Special Health Care Services (CSHCS) is a medical coverage program that provides financial assistance for needed medical treatment to reduce complications and promote maximum quality of life for children, from birth to 21 years of age, with serious and chronic medical conditions.

Eligibility for CSHCS is based on both medical and financial criteria. Medical eligibility requires that a child be under 21 years of age and have a severe chronic medical condition that meets one of the following requirements:

- Has lasted (or is expected to last) at least 2 years
- Will produce disability or disfigurement or limits on function
- Requires a special diet or devices
- Would produce a chronic disabling physical condition if untreated

A family with an income (before taxes) at or below 250% of the federal poverty level may qualify.

Individuals can be enrolled in both the IHCP *and* CSHCS if they qualify for both programs. The EPSDT services must first be billed to the IHCP network (fee-for-service or managed care) to which the child is assigned before submitting the claim to CSHCS. If the child is also enrolled in First Steps and First Steps covers the service, providers should bill First Steps first, and First Steps will coordinate billing the IHCP and CSHCS.

For more information about CSHCS, call (317) 233-1351 or 1-800-475-1355, email cshcscarecoordinatio@isdh.in.gov, or visit the CSHCS website at in.gov/isdh.

Indiana's First Steps Program

Indiana's First Steps early intervention system is a comprehensive, family-centered, community-based program that provides early intervention services to infants and young children with disabilities and those who are at risk for developmental delays. The First Steps program can provide a multidisciplinary evaluation and developmental assessment when children are referred. Early intervention services and/or supports are provided if the child is eligible; the services and supports are not income-based.

Families who are eligible to participate in the Indiana First Steps program include any child, from birth to 3 years old, who:

- Is experiencing developmental delays
- Has a diagnosed condition that has a high probability of resulting in a developmental delay
- Is at risk of having substantial developmental delay because of biological risk factors

All early intervention services must be agreed upon in advance by the child's parents, included on an Individualized Family Service Plan (IFSP), and be provided by qualified personnel. An IFSP is the written plan detailing the early intervention services or supports the child will receive.

All infants and toddlers are entitled to evaluation to determine eligibility, ongoing assessment, and case management. The following services are specifically listed in the regulations. If appropriate for the child and family, they are included in the family's IFSP:

- Audiology
- Case management/service coordination
- Family training, counseling, and home visits
- Health services necessary to enable the infant or toddler to benefit from the early intervention services
- Medical services only for diagnostic and evaluation purposes
- Nursing services
- Nutrition services

- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Special instruction
- Speech-language pathology
- Transportation (direct and related costs of travel)

Although most First Steps agencies can provide all the early intervention services needed by children with developmental delays, IHCP members have the freedom of choice of providers for IHCP-covered services. Families can choose to receive IHCP-covered services from a provider not affiliated with the First Steps program.

In addition to the services children and their families can receive, it is important to get children with suspected or diagnosed developmental delays enrolled in the First Steps program for the following two special reasons:

- To enable eligible children and their families to receive early intervention services based on an IFSP
- To enable eligible children and their families to receive transitioning services when the child turns 3 years old and the Department of Education then becomes responsible for providing services for these children, if eligible, through an Individualized Education Plan (IEP)

For more information about the First Steps program, call 1-800-545-7763 or visit the *First Steps* web page at in.gov/fssa.

Services authorized by First Steps for children who are not enrolled in the IHCP and some CSHCS are billable only to First Steps. Non-First Steps services billed for IHCP members follow normal protocol for each delivery system.

Section 9: Documentation Resources

Documentation for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/HealthWatch screenings should be incorporated into the documentation routinely kept for well-child check-ups. Because only a few activities differentiate EPSDT/HealthWatch screening components and well-child services, it is imperative that those differences be reflected in the member's health record.

When screenings reveal the need for more frequent health exams or monitoring than recommended by the periodicity schedule, interperiodic screenings may be performed. The Indiana Health Coverage Programs (IHCP) covers interperiodic office visits and EPSDT screening exams up to the 30-office-visit maximum per individual, per year.

Review the *Evaluation and Management Services* and *Claim Submission and Processing* modules for information about billing non-EPSDT office visits and the office visit benefit limitation. Additional office visits, other than EPSDT screening exams, must be billed with appropriate evaluation and management (E/M) procedure codes for visits that are not full EPSDT/HealthWatch screenings and **should *not* be billed using Z00.121 or Z00.129** as the primary diagnosis, so that they are reimbursed accordingly. If present and applicable, commercial insurance should be billed first.

The following sections present tools available for physicians' use in simplifying documentation of EPSDT/HealthWatch screening components in medical records.

American Academy of Pediatrics

The Committee on Practice and Ambulatory Medicine publishes the Academy's preventive care guidelines, which can be accessed from the *Periodicity Schedule* page at aap.org. Also known as the periodicity schedule, the guidelines set forth recommendations for the periodicity of the well-child visits and the types of screens and health assessments that should be conducted at each visit.

The Family and Social Services Administration (FSSA) has identified the American Academy of Pediatrics (AAP) periodicity schedule to be "best practice" and supports the schedule as the appropriate guidelines for EPSDT services.

If you have any questions, contact the Council on Community Pediatrics toll-free at 1-800-433-9016 or see the American Academy of Pediatrics website at aap.org.

Bright Futures

Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice.

The history of the patient is an important factor in making a proper assessment of the patient's health. The EPSDT/HealthWatch screening physician has the responsibility of obtaining a family and medical history as part of the EPSDT screening examination.

The *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* at brightfutures.aap.org has resources for documenting the components of EPSDT services for all ages.

Certainly, no health provider has the time to do every intervention discussed in the Bright Futures guidelines for each age visit. The FSSA has committed to put into practice the guidelines set forth by the AAP, as described in the *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.*

For complete information about Bright Futures, see the Bright Futures website at brightfutures.aap.org or contact Bright Futures at:

Bright Futures at AAP
American Academy of Pediatrics
Bright Futures National Center
141 Northwest Point Blvd.
Elk Grove, IL 60007

Email: brightfutures@aap.org

The following information can be obtained at the Bright Futures website:

- Previsit Questionnaires
- Supplemental Questionnaires
- Visit Documentation Forms
- Medical Screening Questionnaires
- Parent/Patient Education Handouts
- Guidelines for Health Supervision

Centers for Disease Control and Prevention, National Center for Health Statistics

A detailed medical growth chart designed for each age group is available from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS). The CDC can be contacted in one of the following ways:

Centers for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30329-4027

Toll-Free Telephone: 1-800-232-4636
Website: Contact CDC-INFO at cdc.gov/growthcharts

Providers are also encouraged to periodically check the CDC NCHS website at cdc.gov for announcements and updates about distribution and training materials.

Indiana State Department of Health

The Indiana State Department of Health (ISDH) uses the *Recommendations for Preventive Pediatric Health Care* for the care of children who are receiving competent parenting, have no manifestations of any major health problems, and are growing and developing in satisfactory fashion. These guidelines represent a consensus by the Committee of Practice and Ambulatory Medicine in consultations with the national committees and sections of the AAP.

For more information, contact:

Indiana State Department of Health
Maternal and Child Health Division
2 N. Meridian St.
Indianapolis, IN 46204

Toll-Free Telephone: 1-844-6667
Fax: (317) 233-7940
Email: ISDHMCH@isdh.in.gov
Website: in.gov/isdh/19571.htm